No. 8
2023

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

QPS TalkTime

A community of quality and patient safety improvers

Patient Safety Together at Tipperary University Hospital

16th March 2023 | 13.00 - 14.00

How we are running today's session

- You will be muted but the chat is open throughout - please post any questions or comments there and we will address them after the presentation.
- If your tech fails, don't worry - we're recording the main session so you can watch back on the NQPSD YouTube channel and access the slides at your convenience.
- Audio is available via your PC or dial in:

  Telephone no: +353-153-39982 Ireland Toll | +353-1526-0058 Ireland Toll 2

  Event number: 2734 054 1974#
- Please feel free to continue the discussion on Twitter:

  @QPSTalkTime | @NationalQPS | @juanita.guidera | @mapflynn | @johnfitzsimons9 | @mariaba01464133

  #QIreland | #patientsafety
- Please help us to improve our QPS TalkTime Webinars by completing a short feedback form (pop up window before you log out).
- You will receive an email from QPS TalkTime confirming your attendance.

Our objectives

At our upcoming webinar, we will explore:

- Examples of & key learnings from implementing quality improvement in Tipperary University Hospital including:
  - Pink Safety Magnet
  - Critical Care Skills - simulation training
  - Medication Safety during a Paediatric Emergency
  - Elimination of Hospital Acquired Clostridioides difficile
- The impact on patient safety of multidisciplinary teamwork, psychological safety and an emphasis on culture.
- How quality initiatives and a learning culture have improved practice and patient experience.

To get started … we invite you to

Share using the chat box:

Your name, work and where you are joining us from …

Finish this statement:

Is Quality Improvement part of normal work or an add on?

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Pink Safety Magnet

Shannon Power

Clinical Skills Facilitator for the medical and surgical wards

Tipperary University Hospital
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A University Affiliated Acute Hospital
Teaching | Understanding | Healing

HSE

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Pink Safety Magnet

SHANNON POWER

CLINICAL SKILLS FACILITATOR MEDICAL/SURGICAL

What is the safety magnet?

Placed beside patient names on a whiteboard so staff can see instantly which patients other staff are concerned about or patients who have deteriorated

Bright pink to ensure it is easily visible on patient whiteboards so that staff can see instantly the patients of concern on a ward

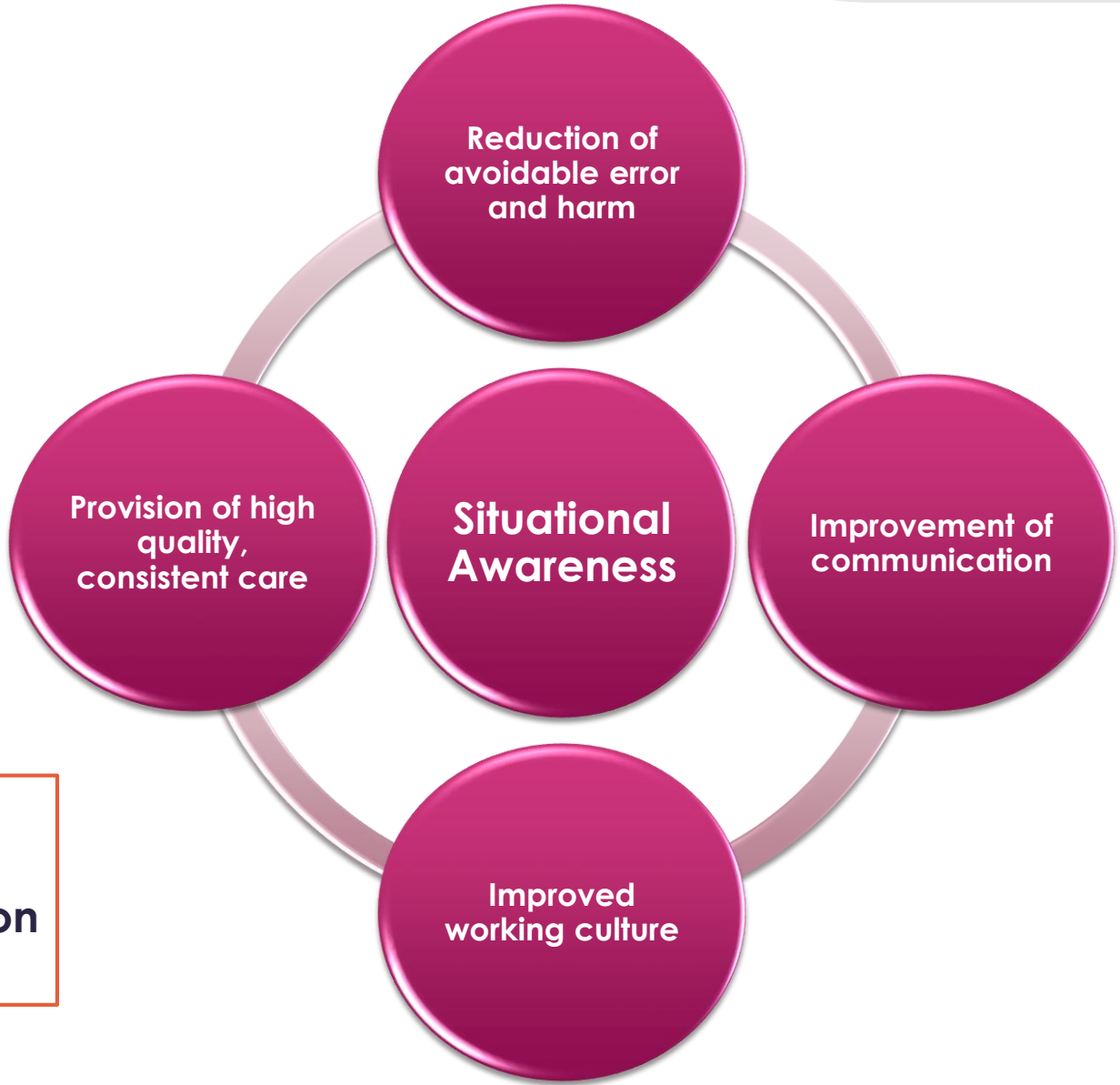
Designed to create situational awareness for everyone in the clinical area

Reminds staff to use the pink ISBAR deteriorating patient stickers to escalate the patient

Where did the safety magnet come from?

1. CNM raised a query about having a document for safety huddles to be able to have a record of patients of concern
2. Having attended the RCPI SAFE Programme, I adapted a ‘safety huddle’ sheet for the ward to use for nursing huddles
3. The ‘safety huddle’ sheet was seen as extra paperwork
4. Reviewed NCEC Clinical Guidelines no.1 and no.11 and how I could introduce something which would identify patients of concern quickly without paperwork
5. Looked at our local INEWS policy and ISBAR stickers and decided to introduce a pink magnet to place beside patient names on a whiteboard
6. Developed a guideline for staff about the pink safety magnet which was reviewed by the Nurse Practice Development ADON and three CNM2s
7. Disseminated the guideline to all staff and uploaded to Q-pulse
8. Educated staff on the wards about the pink safety magnet and its use

Situational awareness



Situational Awareness
The ability to anticipate and act on needs based on surrounding events

How is the safety magnet working?

- ADONs, CNM3s, CNM2s and CNM1s asked for their opinions

Students are always keen to learn what the safety magnet means on the whiteboard and why it is used

Alerts me to patients I was unaware were unwell

I think they are great – as they highlight to everyone on duty who the sickest patients are throughout everyone's shift

It is a prompt for me to ask about the condition of that patient while on rounds

beneficial to nurses in other sections to be aware of unwell/at risk patients

What is next for the safety magnet?

- Audit of safety huddle paperwork and whiteboards on wards to identify if patients discussed during safety huddles have a pink magnet placed beside their name
- Continued safety huddles and regular reminders to update patient whiteboards and pink safety magnets
- Continued bi-annual INEWS Clinical Guideline No.1 audit to evaluate the INEWS Escalation and Response Protocol and Modified Escalation and Response Protocol Completion
- Digitalisation of INEWS in Tipperary University Hospital
- Continued staff education around the safety magnet
- Implementation of education around the safety magnet into structured study days

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Critical Care Skills

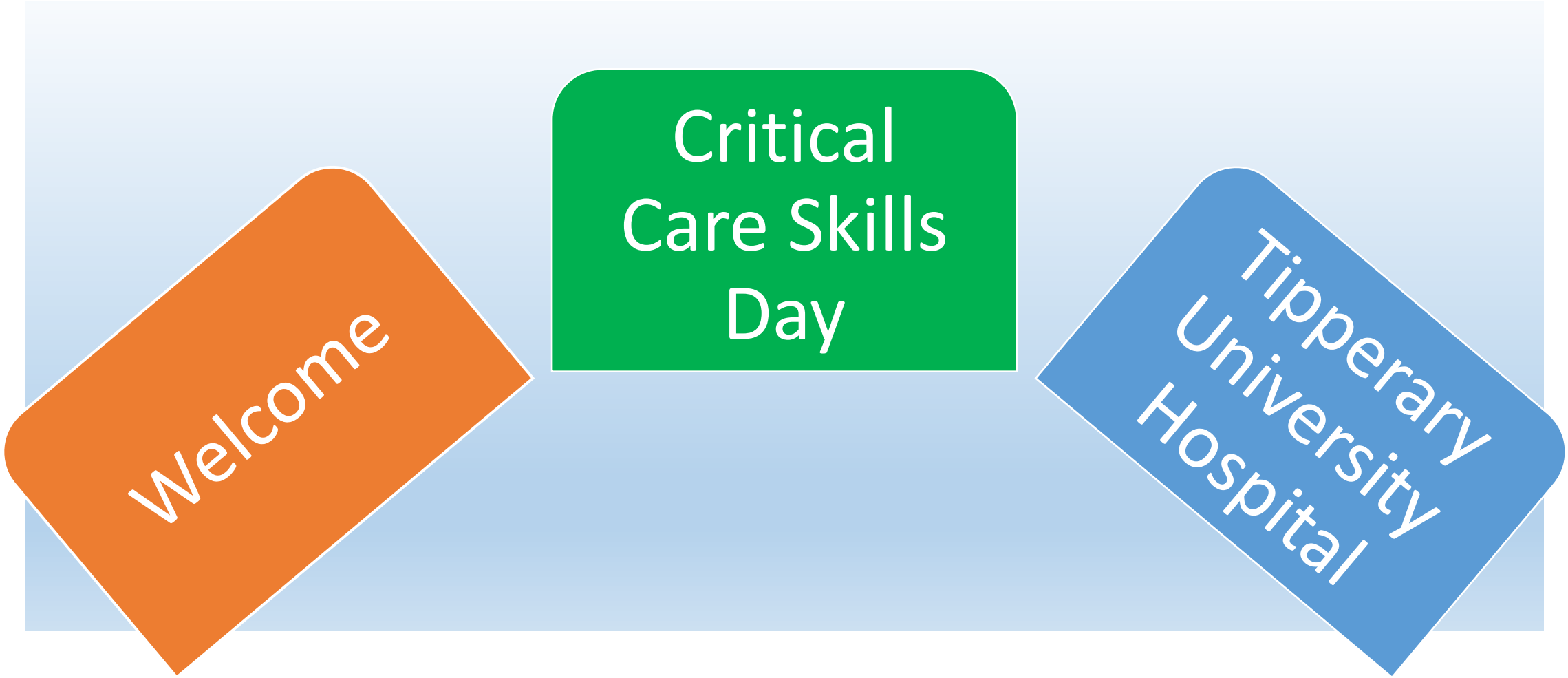
Dr. Andri Engelbrecht,
Consultant in Emergency Medicine

Ailish Mansfield
Clinical Skills Facilitator-Critical Care Intensive Care Unit and Coronary Care Unit

Sarah-Jane Weissenbach,
Clinical Skills Facilitator for the ED and AMAU in 2022 and member of the Nurse Practice Development Team

Dr. Marcella Lanzinger,
Consultant Anaesthesiologist and Clinical Director Critical Care Medicine

Nurse Practice Development Department



Team Introduction

Clinical Skills Facilitators:

Sarah Jane Weissenbach; Ailish Mansfield & Shannon Power

Consultants:

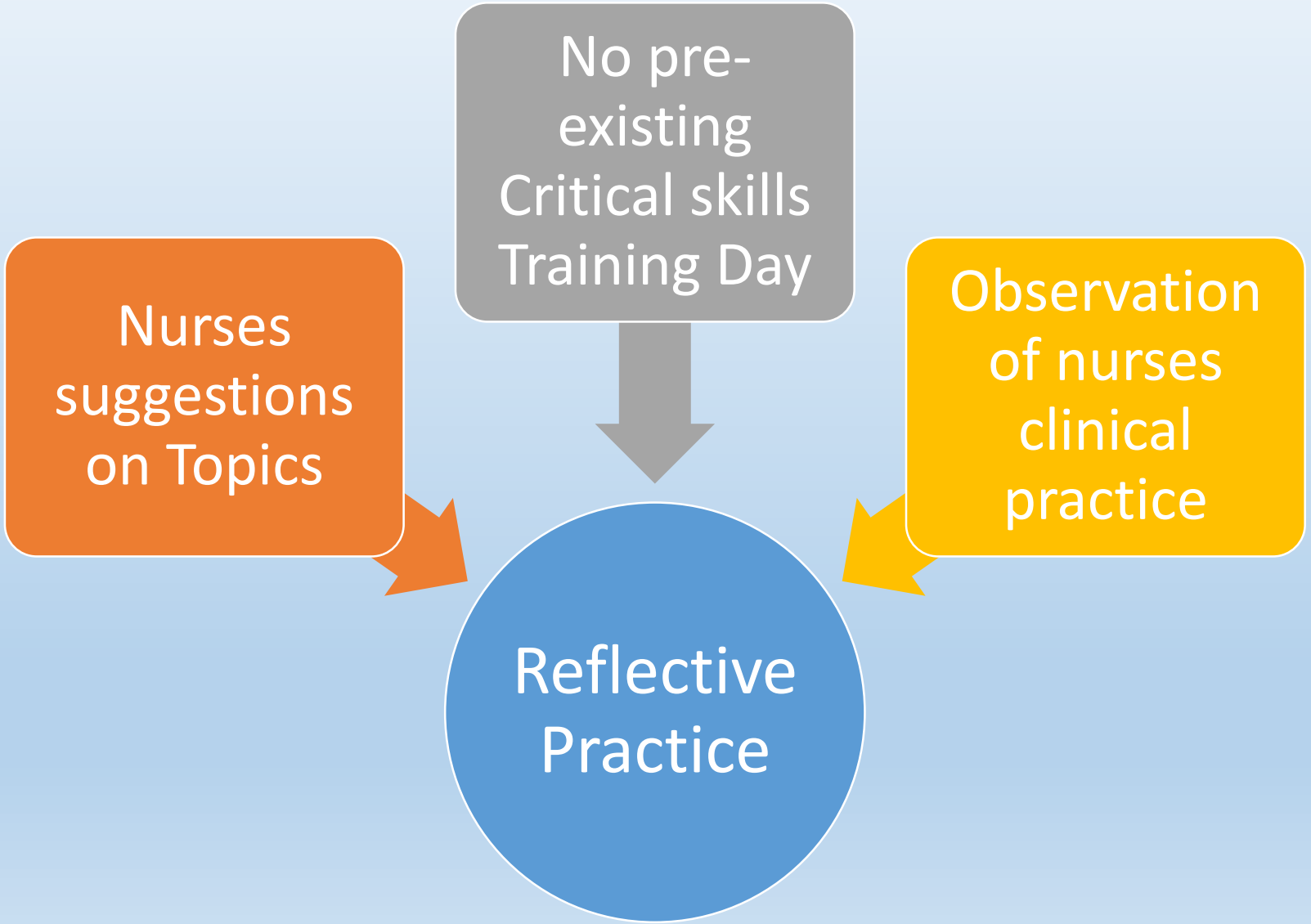
Dr Andri Englebrecht (Consultant Emergency Medicine)

Dr Marcella Lanzinger (Consultant Anaesthetist | Clinical Director Critical Care Medicine)

Practical skill station facilitators:

Mary Walsh (CNM 2 ICU), Adela Burke (Haemovigilance Officer)

Background


No pre-existing Critical skills Training Day
Nurses suggestions on Topics
Observation of nurses clinical practice
Reflective Practice

Overview


Patient safety
Building relationships
Delivering high quality care
Competence
Collaborative work practices

Constructive Alignment

Learning outcomes

Teaching & learning activities

Assessment

Practical Skills Stations

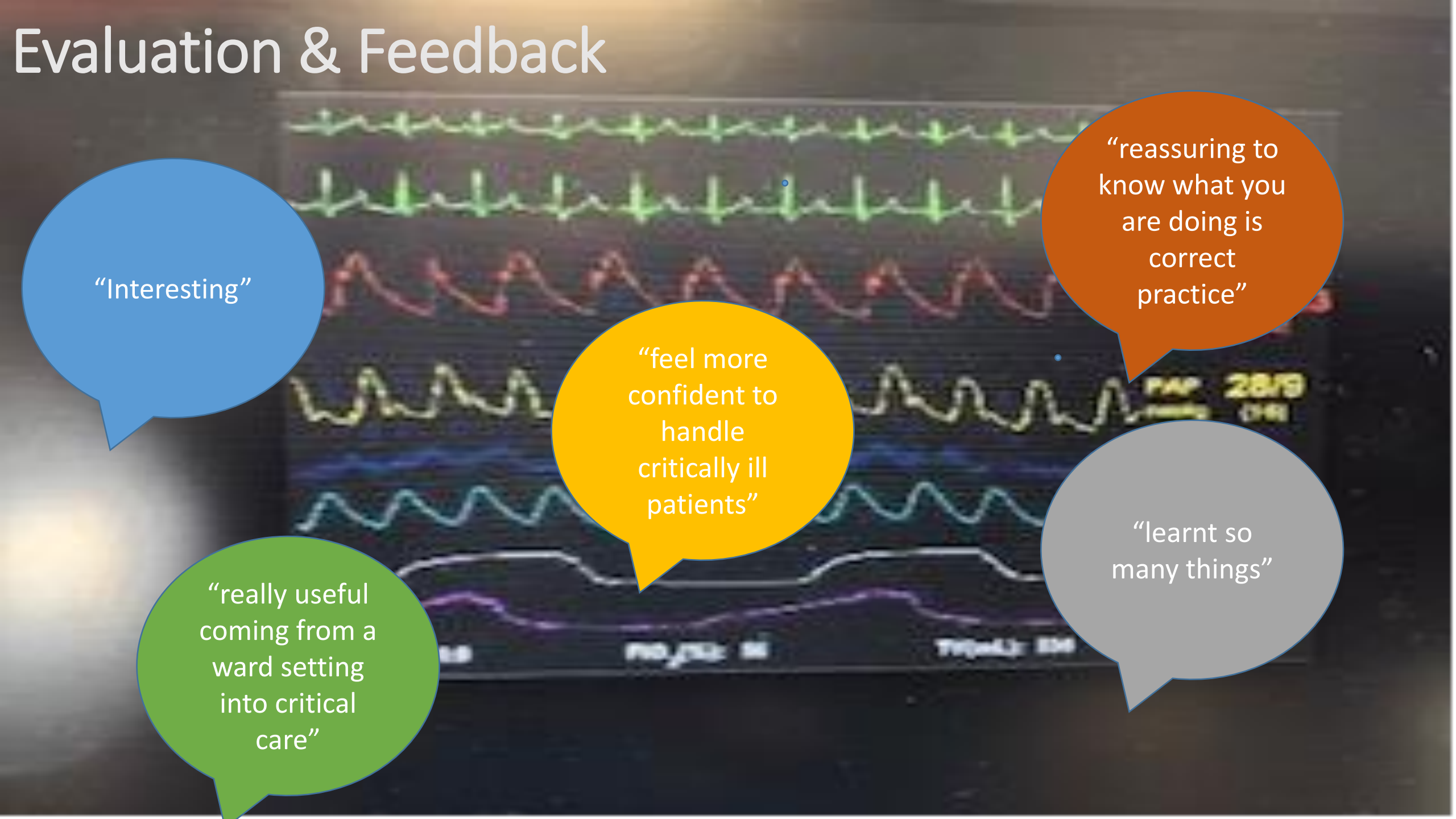
Respiratory failure

Gastro-intestinal Bleed

Myocardial Infarction

Traumatic Brain Injury

Evaluation & Feedback



Thank you for listening.

If you have any further questions, you can contact us at:

sarahjane.weissenbach@hse.ie
ailish.mansfield@hse.ie
andriet.engelbrecht@hse.ie
marcella.lanzinger@hse.ie

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Enhancing Paediatric Patient Safety Medication Safety during a Paediatric Emergency

Heather Power CSF

Clinical Skills Facilitator

Nurse Practice Development Department

Heather Power CSF
Enhancing Paediatric Patient Safety

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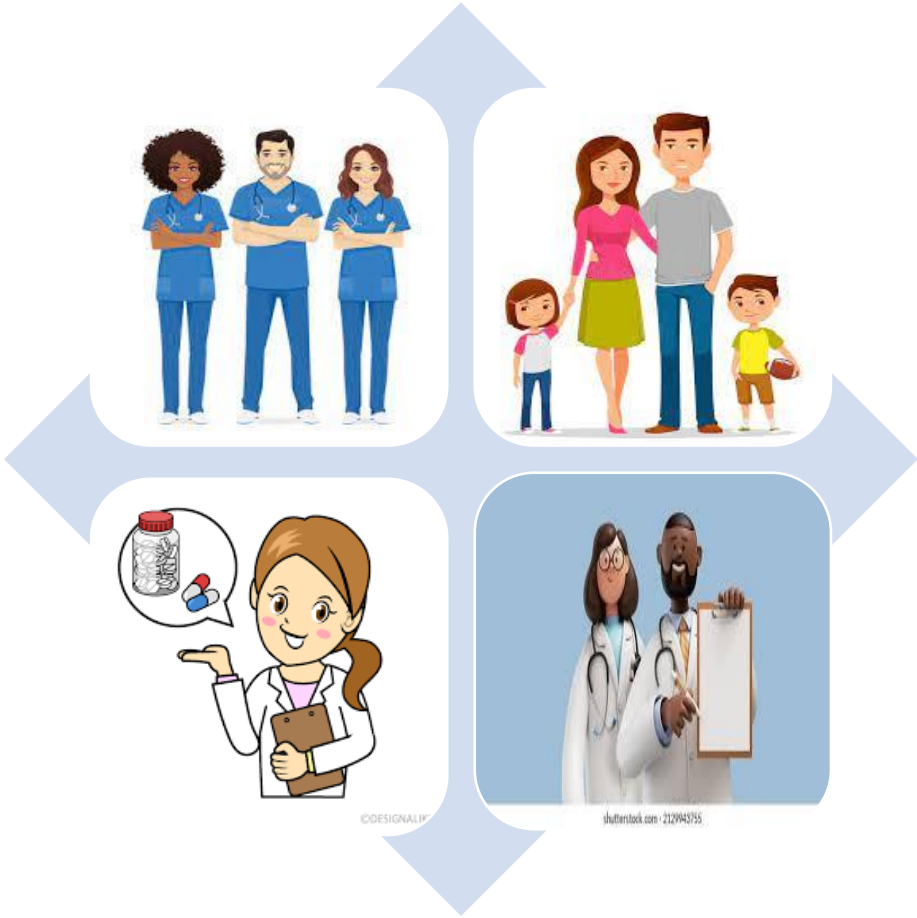
Magnet4Europe

Identification of a Problem

Critically Sick Child

Complex drug calculations

Who is involved?



Developing a Solution

Calculations tool long & complex

Drug preparation sheets

Safe
Efficient
Accurate
Care

Emergency Medication

Morphine

Midazolam

Nor Adrenalin

Phenytoin

Dopamine

Magnesium

MORPHINE INFUSION PREPARATION

Prescription; 5-20 micrograms/kg/hr continuous I.V. infusion.

Standard dilution:
Dilute 1 milligram/kg up to final volume of 50 ml with NaCl 0.9% or Dextrose 5%
i.e. 22kg child would have 22milligrams in 50 ml
Maximum concentration is 1mg/ml i.e. 50mg in 50ml

e.g Child weighing 7.5 kg prescribed 10 micrograms/kg/hr

$$\frac{\text{dose} \times \text{weight}}{\text{total mcg in syringe}} \times \text{volume} = \text{rate (ml/hr)}$$

$$\frac{10\ \text{mcg} \times 7.5}{7500} \times 50\text{ml} = 0{,}5\text{ml/hr}$$

This is a guide to preparation of infusion NOT a prescription.

PLEASE REFER TO CHI PAEDIATRIC CRITICAL CARE INTRAVENOUS CHART FOR DILUTION INSTRUCTIONS AND COMPATIBILITY. *(CHI VERSION 2 FEB 2021)*

MIDAZOLAM INFUSION PREPARATION (for Sedation)

Prescription; 0 -4 micrograms/ kg/min. continuous I.V. infusion.

Standard dilution:
< 15kg - 3 milligrams/kg dilute up to 50 ml final volume.
> 15kg – 50 milligrams made up to 50ml final volume.
Dilute with NaCl 0.9% or Dextrose 5%

e.g. <15kg Child weighing 12kg prescribed 4 micrograms/kg/min

(Weight x 3milligrams = 36milligrams diluted up to 50ml)

$$\frac{\text{dose} \times \text{weight} \times \text{minutes}}{\text{total mcg in syringe}} \times \text{volume} = \text{ml/hr}$$

$$\frac{4\text{mcg} \times 12\text{kg} \times 60\text{mins}}{36000\ \text{mcg}} \times 50\text{ml} = 4\ \text{ml/hr}$$

e.g. >15kg Child weighing 22kg prescribed 2micrograms/kg/min

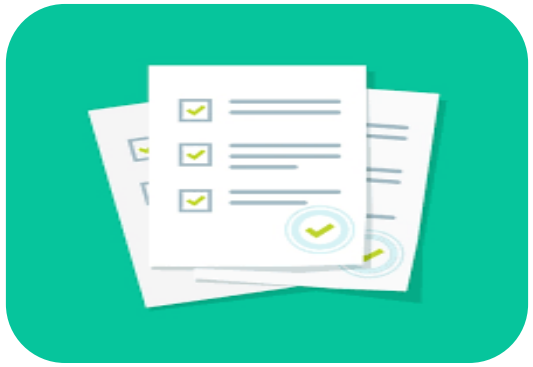
(50 milligrams diluted up to 50ml)

$$\frac{2\text{mcg} \times 22\text{kg} \times 60\text{mins}}{50000\ \text{mcg}} \times 50\text{ml} = 2.64\text{ml/hr}$$

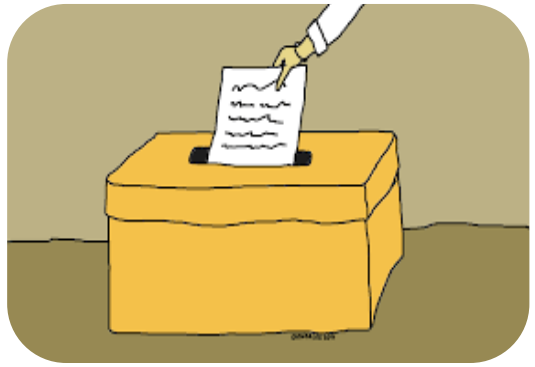
N.B. This is a guide to preparation of infusion NOT a prescription.

PLEASE REFER TO CHI PAEDIATRIC CRITICAL CARE INTRAVENOUS CHART FOR DILUTION INSTRUCTIONS AND COMPATIBILITY. *(CHI VERSION 2 FEB 2021)*

Education



Regular practice

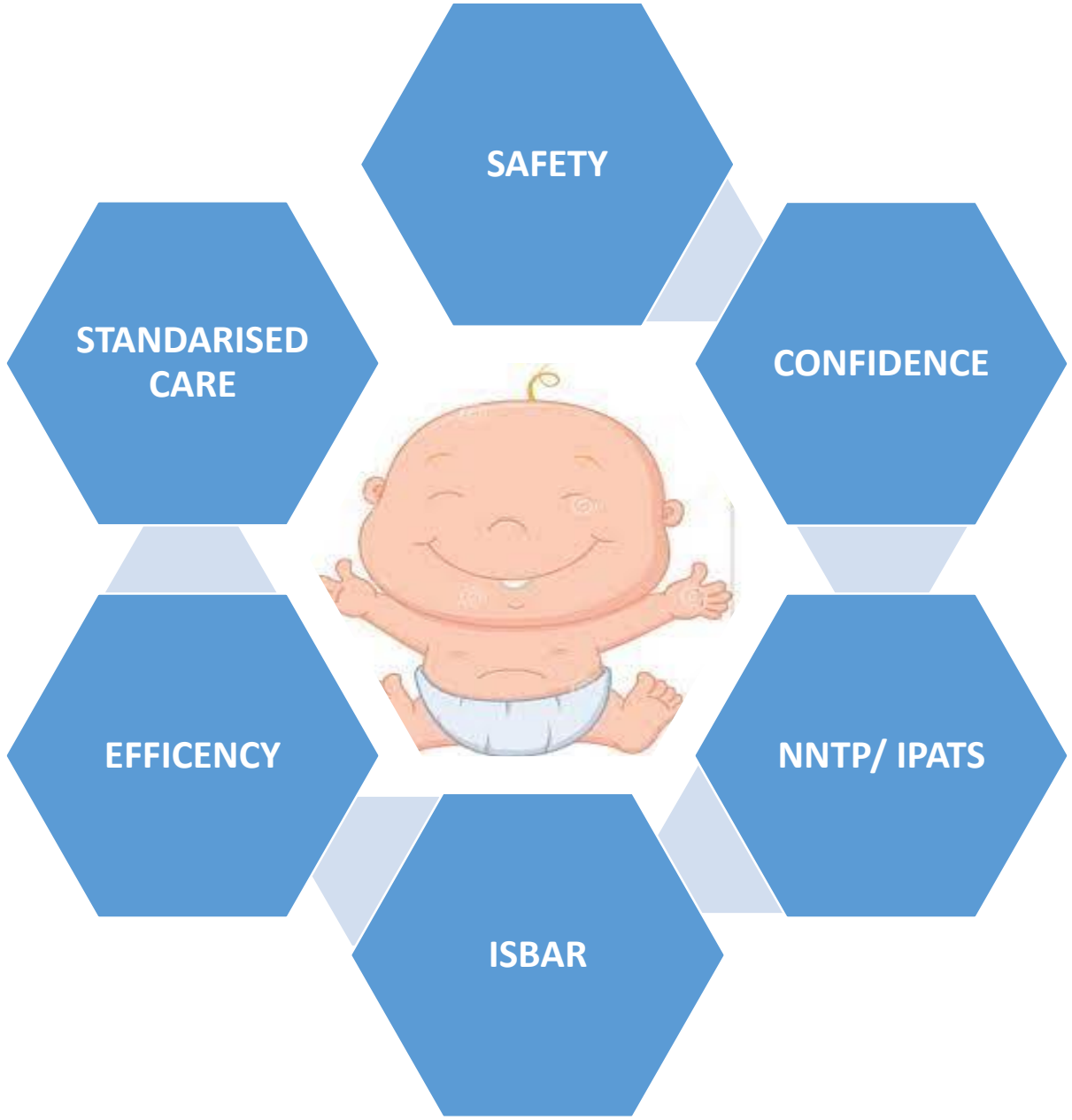


Anonymous Feedback

IPATS
Irish Paediatric Acute Transport Service

IPATS feedback

OUTCOME


SAFETY
CONFIDENCE
NNTP/ IPATS
ISBAR
EFFICENCY
STANDARISED CARE

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Elimination of Hospital Acquired *Clostridioides difficile* in a HSE Model 3 Acute Hospital

Dr Sumera Bashir,
Paeds Registrar

Elaine Egan,
Patient Safety Strategy Coordinator
S/SWHG

Audrey O Reilly,
Chief Pharmacist

Elimination of Hospital Acquired *Clostridioides difficile* in a HSE Model 3 Acute Hospital

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Clostridioides difficile Quality Improvement Team

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Our team

Project Team:

- Dr Sumera Bashir, Paeds Registrar, TippUH
- Audrey O Reilly Chief Pharmacist, TippUH
- Elaine Egan, Patient Safety Strategy Coordinator S/SWHG

(with support from the RCPI faculty for PG Cert in Quality Improvement Leadership in Healthcare)

Other team members:

- Sponsors: Maria Barry, Hospital Manager & Dr A Majeed, Clinical Director
- Current Collaborators: Cons Geriatrician/ Gen Med & Team, Cons Endocrinologist / Gen Med & Team, Gastro SpR, Antimicrobial Pharmacist, Clinical Pharmacists, Ward CNMs, IPCT, Clinical Microbiologist, Support Services, Hospital Management & Patient Representative Group
- Future Collaborators: Patient carer, All TippUH Prescribers, AMRIC, national C diff working group

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Clostridioides difficile Infection (CDI)

Do your bit - Do not transmit

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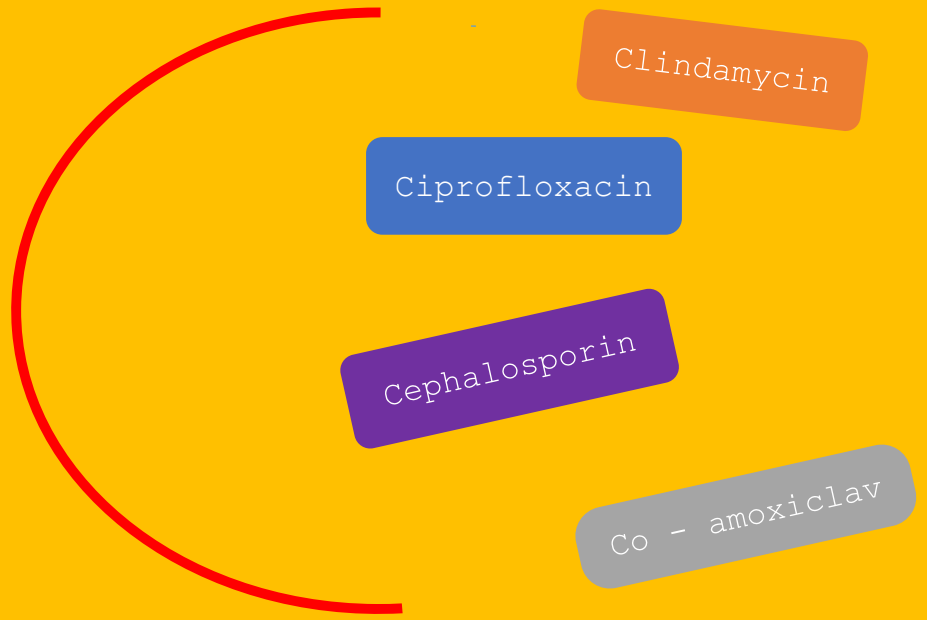
Risk factors

- Recent or multiple antibiotic use
- > 65 years of age
- Co-morbidities
- Recent hospital/ nursing home admission or exposure to person with CDI
- Immunosuppression
- Recent gastric surgery
- Previous history of C diff

SIGHT

S: Suspect a case may be infective where there is no clear alternative cause of diarrhoea.
I: Isolate the patient in a single room consulting with IPCT
G: Gloves & aprons must be used for all contact with the patient & their environment.
H: Hand decontamination should be carried out with alcohol hand gel or liquid soap. Hand washing with soap after contact with the patient and the patient's environment is required if gloves have not been worn/gloves have been breeched or if there is visible contamination of the hands despite glove use.
T: Test the stool for *C. difficile* toxin & other pathogens. Send stool to lab immediately

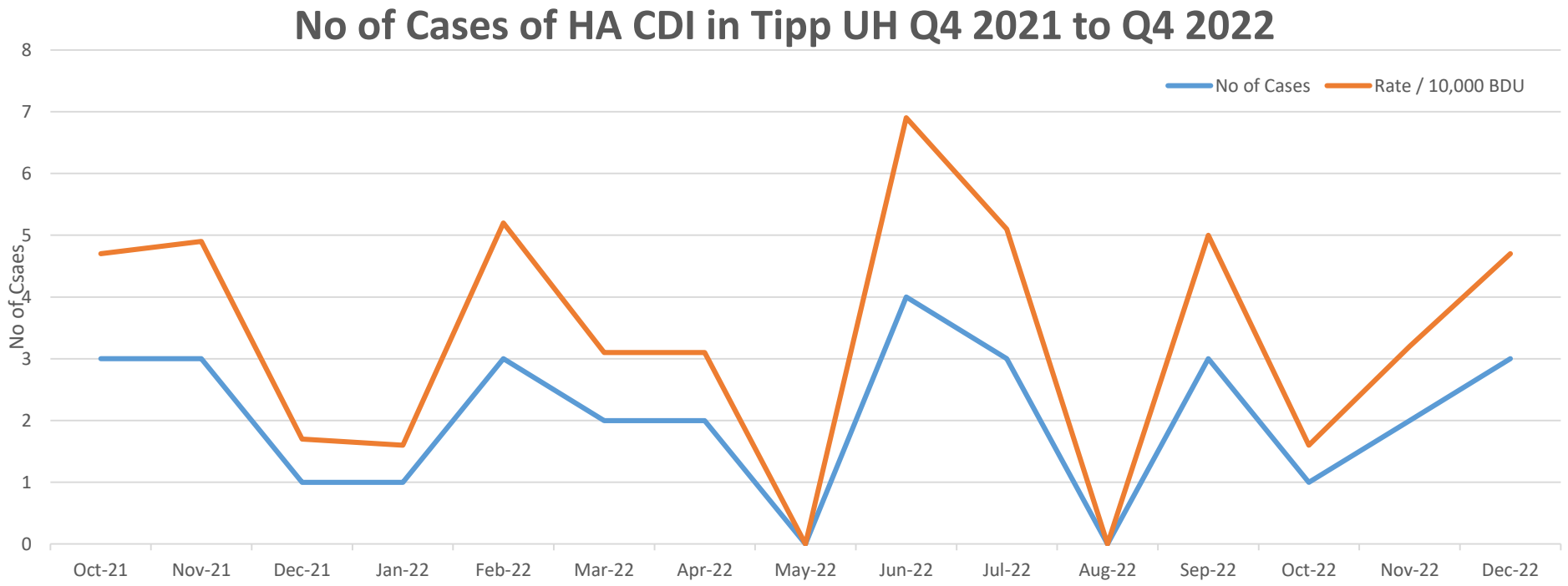
High Risk -The 4 Cs



Be Aware

- Hand hygiene- wash your hands
- Cleaning and disinfection of environment
- >3 episodes of diarrhoea (loose watery liquid stool) in 24 hours: send sample
- Isolation room – PPE & inform IPC
- Regular review of antibiotics & proton pump inhibitors
- Avoid laxatives
- Give patient information sheet/advice

TippUH Incidence of Hospital Acquired *Clostridioides difficile* – Baseline data*



Information taken from the Surveillance data received from the BIU*

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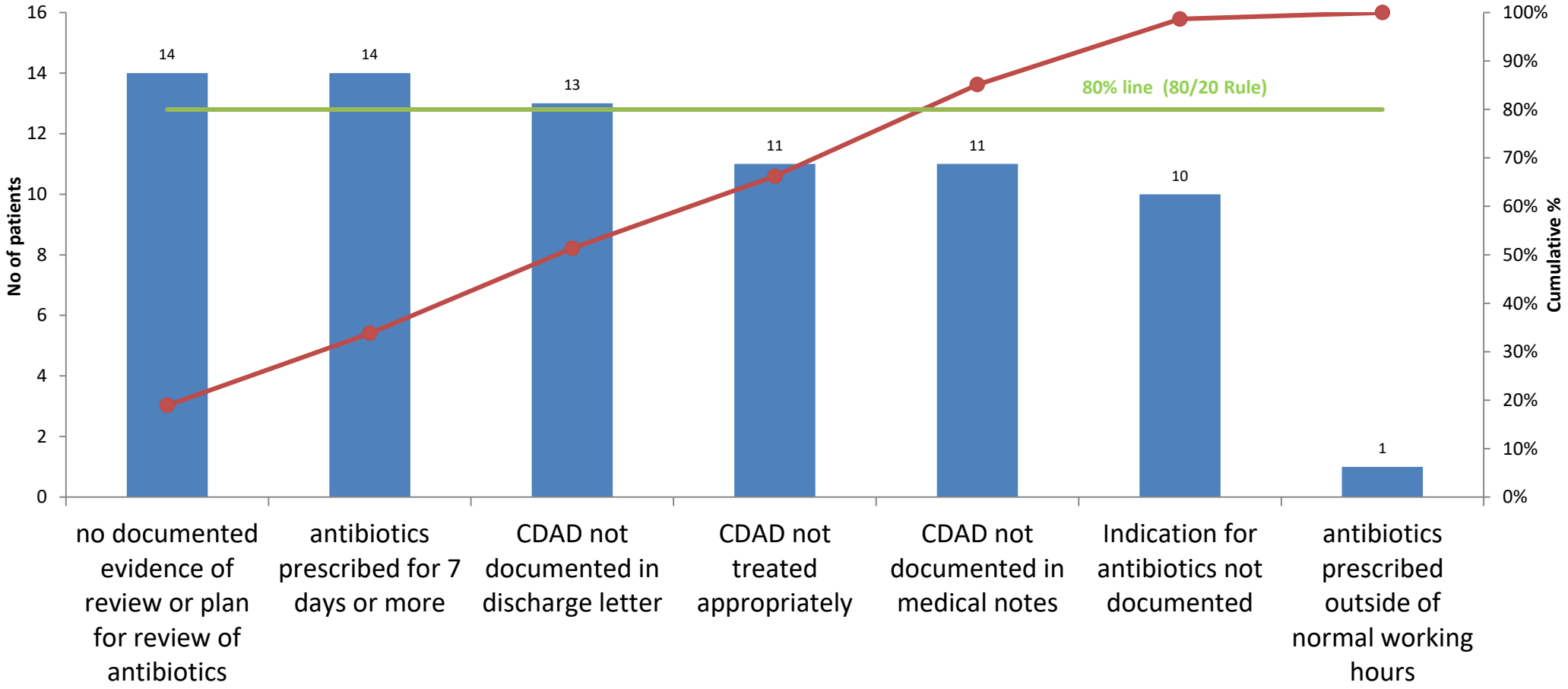
Baseline Audit of Hospital Acquired CDI in Tipp UH June 2022 to Dec 2022



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PDSA 01
Task- Task-related

Prediction: There is poor documentation regarding indication, review and duration of antibiotics prescribed.

Plan: Establish baseline data **Do:** Retrospective chart review of known HA CDI June 2022 – Dec 2022

Study: Display results bar chart **Act**: Present findings to Hospital Management team & identify consultant to work with us

Changes made: Convene a stakeholder meeting with Geriatric consultant

PDSA 02
Develop a Change

Prediction: Consultant engagement will help identify change ideas for improvement

Plan: Feedback on baseline audit results **Do**: Look for suggestions for improvement

Study: Clinical Pharmacist to attend ward rounds **Act**: Pharmacist to commence ward round on agreed date

As predicted: Feeding back baseline audit results and requesting ideas for solutions was beneficial for buy-in

Changes made: Pharmacist to attend ward round for 2 weeks staring on 11.01.23. Dates agreed for Pharmacist to attend ward rounds

PDSA 03
Implement a change and test a change

Prediction: Pharmacist attending consultant–led ward round will prompt the team to review antibiotics prescribed.

Plan: Pharmacist to attend ward round twice a week from 11.01.23 **Do**: Prompt the team to review antibiotics prescribed

Study: Retrospective review of medical charts for 2 weeks from 11.01.23 **Act**: Schedule stakeholder group meeting 31.01.23

As predicted: it was found an improvement of indication, of review/plan for antibiotics and durations were seen

PDSA 04
Further develop a change

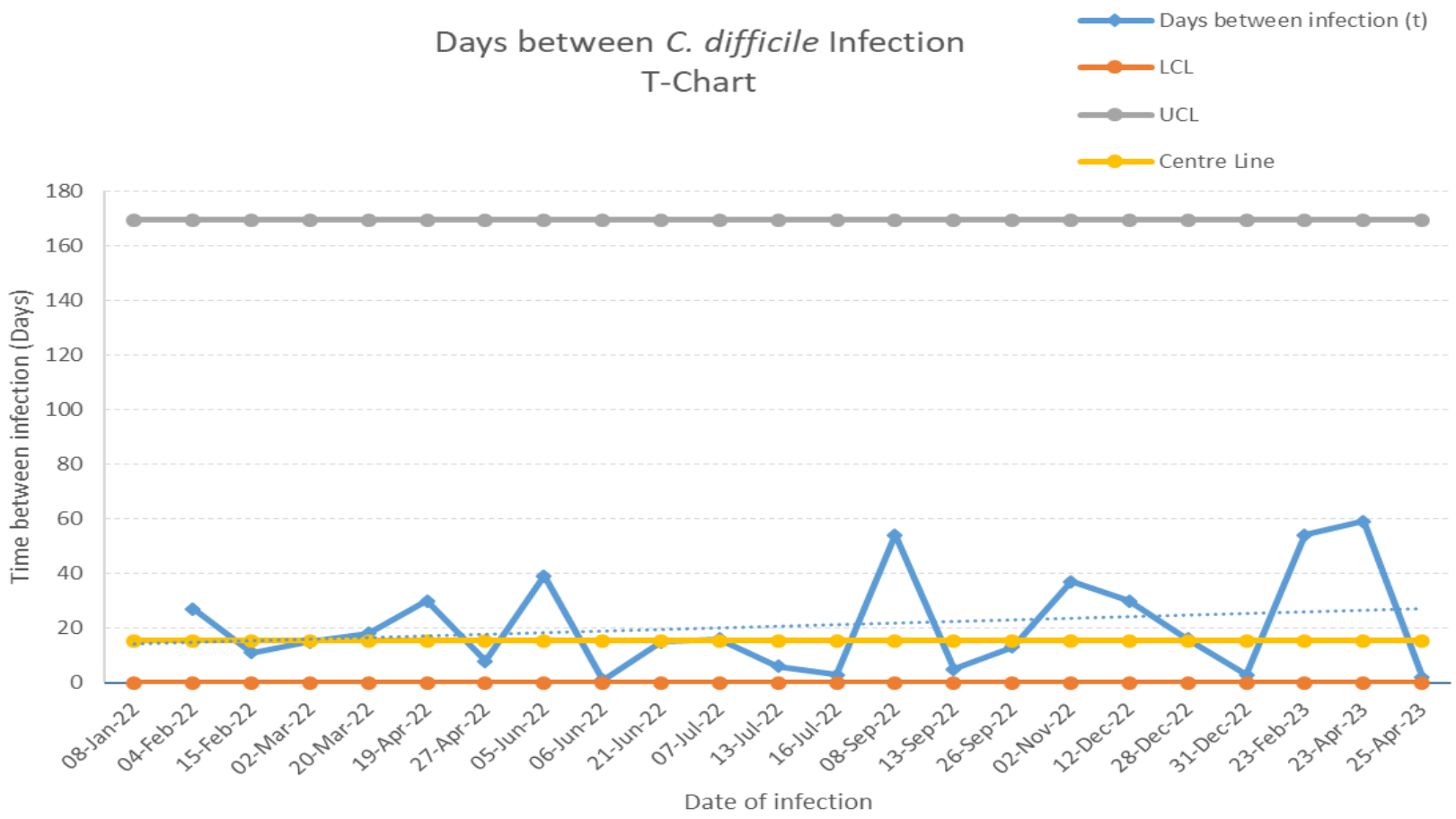
Prediction: Reporting back to stakeholders will identify that further change can create more improvement i.e. a new PDSA

Plan: Scheduled a meeting with stakeholder group **Do**: Stakeholder meeting held on 31.01.23

Study: Review & discussion of audit results abx section **Act:** Senior person on the rounds to hold med chart in their hand & review

As predicted: on going engagement from consultant led team to further improve process measure results

Measuring that change makes a difference



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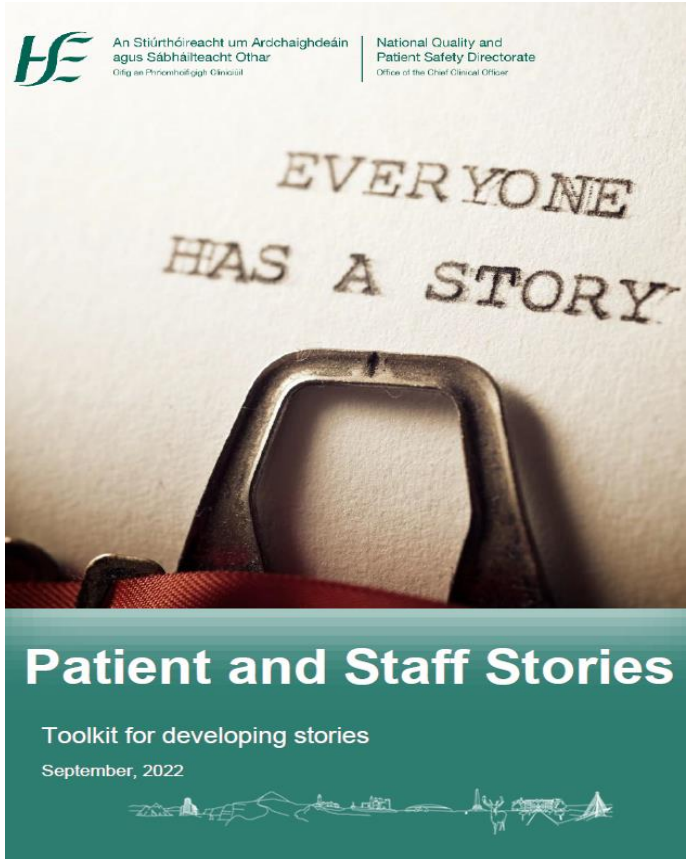
Engaging Patients and Family and Our Staff

- Attended Tipp UH Patient Representation Group meeting 24 04 2023 and introduced the project
- Feedback on PIL requested by 31 05 2023
- Developing a patient story with a shared care paediatric patient
- Attended CNM meeting 09 05 2023
- Provided update at TippUH CDI Action Group – senior management in attendance



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PDSAs in the Pipeline

- IPC Alert for previous CDI on IPMS patient file
- Display of safety cross
- Display of poster
- Moving pharmacist to new team
- Presentation at Tipp UH Quality Day 17 05 2023
- Patient Story
- Review of CDI PIL
- Use the data from PPS in Nov 2022 & compare to upcoming May 2023 PPS
- Timeliness of stool samples
- Follow up of management of HA CDI cases in 2023

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- 20 presentations – over 30 presenters
- 36 posters involving over 50 staff
- All disciplines involved
  - Nurse Practice Development- Clinical skills facilitators
  - Technical Services,
  - Support Services,
  - Medical
  - Catering
  - MDT Critical Care,
  - Nurse Specialists: CIT OPAT, Haemovigilance, IBD, Nutritional support
  - Health Care Assistants
  - Newborn screening
  - ED, Theatre, Maternity, Paediatrics, Cardiology, Care of elderly
  - Radiology, Speech & Language Therapy, Physio, Pharmacy, Dietetics, Cardiac Diagnostics.
  - Nursing Council
  - QI MDT teams

  Supported by Patient Services Users Representative Forum & Inclusion Working Group

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Time	Title	Presenter
M.C. Maura Grogan, Quality Manager		
Chairperson: Ms. Tina Boland, Project Lead, National Care Experience Programme, HIQA.		
09:05	Welcome	Ms Maria Barry *General Manager*
09:15	Investigating the experiences and opinions of deaf service users within the Radiology Department	Jennifer O' Riordan *Radiology*
09:30	Newborn Hearing Screening	Karen Halford *Newborn Screening*
09:45	Addition of IBD CNS to the gastroenterology team for management and support of patients with IBD.	Aoife O'Brien *Clinical Nurse Specialist*
10:00	The Effect of Contact Radiation Shielding on Breast dose during CT Abdomen-Pelvis: A Phantom Study	Maria Long *Radiology*
10:15	Community Intervention Team (CIT) & Outpatients Parenteral Antimicrobial Therapy (OPAT)	Denise Conway *Clinical Nurse Specialist*
10:30	Critical Skills Training Programme	Ailish Mansfield, Sarah Jane Weissenbach, Dr. Marcella Lanzinger & Dr. Andriet Engelbrecht *ED & Critical Care*

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Time	Title	Presenter
10:45-11:15	COFFEE + Poster viewing in Marquee	
	Chairperson Ms. Maria Lordan Dunphy, Assistant National Director, Quality & Patient Safety Directorate, Lead for Patient Safety Strategy, HSE National Centre for Clinical Audit and Quality Improvement.	
11:15	Pink Safety Magnet	Shannon Power *Nurse Practice Development*
11:30	Oxygen & Suction Collaboration: Safety for All	Anna Butler & Jimmy Ryan *Nurse Practice Development & Technical Services*
11:45	Head Injury presentations to ED: Time to Care	Dr. Mosaab *Medical*
12:00	AI Rapid Software in CT	Marina Quinlan *Radiology*
12:15	Training, A collaboration between Theatre & Maternity	Catherine Browne & Maggie Dowling *Nurse Practice Development & DOM*
12:30	Overview of the Benefit of referral for CGA for the Older Person admitted to an Acute Setting	Eamonn Cooney & Dr. Arslan Sohail *Advanced Nurse Practitioner & Consultant Physician*
12:45	Elimination of Hospital Acquired *Clostridioides difficile* in a HSE Model 3 Acute Hospital.	Audrey O'Reilly, Elaine Egan & Dr. Sumera Bashir *Pharmacy, Patient Safety & Paediatrics*

Quality Department May 2023

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Time	Title	Presenter
13:00-14:00	LUNCH + Poster viewing in Marquee	
Chairperson: Ms Jo Lonergan, Patient Service Users Representative Forum Tipperary University Hospital		
14:00	Catering	Margaret Bergin *Catering*
14:15	Quality & Safety Walk Rounds	Elaine Egan *Patient Safety Strategy Co-ordinator*
14:30	Dry Heat Packs for Phlebotomy	Tanja Coonan *HCA*
14:45	Nursing Council	Jacqueline McEvoy *Nursing Council*
15:00	Welcoming iPMS to TippUH Physiotherapy OPD	Angela Radley *Physiotherapy*
15:15	We're All In This Together	PJ Ryan *Support Services*
15:30	Quality Self Care	Izabella Savage *Support Services*
15:45	Prize Giving	
16:00	Closing Address	

Tipperary University Hospital Quality Day May 17th 2023 has been approved for:
Royal College of Physicians Ireland (RCPI) 5 CPD credits
Nursing & Midwifery Board of Ireland (NMBI) 6 CEU credits

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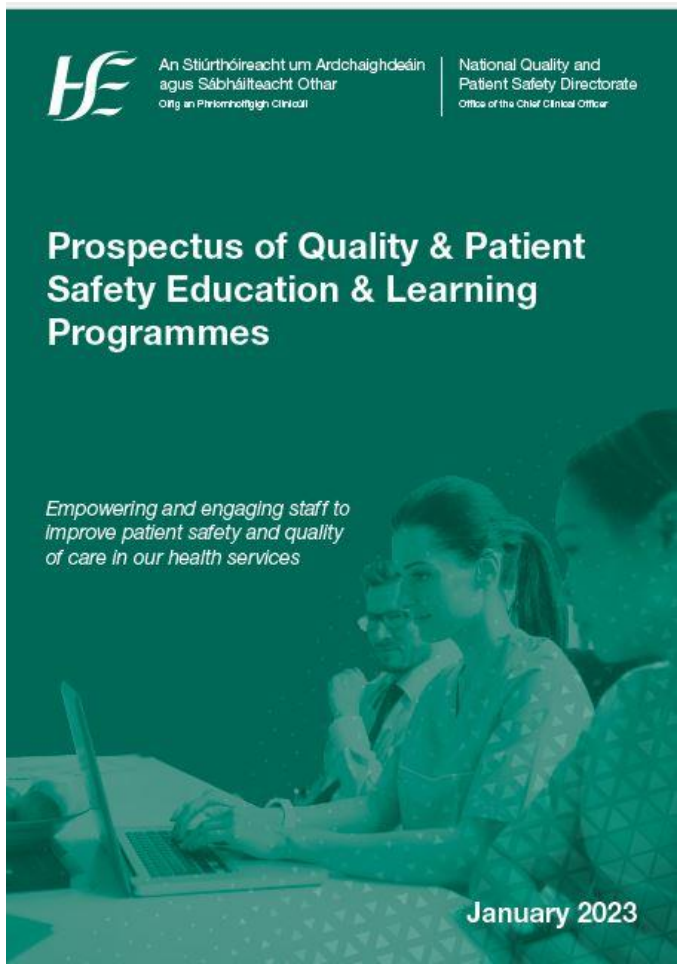
Hearing your thoughts and comments

Quality & Patient Safety Prospectus 2023



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- Schwartz Rounds
- Liberating Structures
- Data for Decision Making
- Complaints, Governance & Learning
- Governance & Risk
- Safeguarding
- Antimicrobial Resistance & Control (AMRIC)
- Change & Innovation
- Library Services
- Connecting with QPS

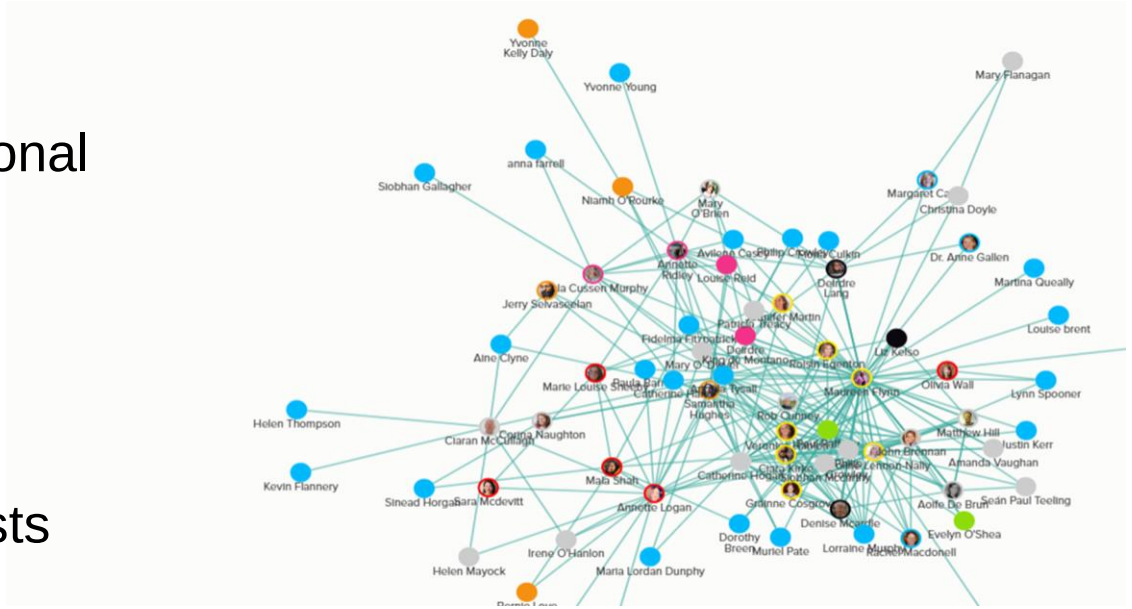
https://www.hse.ie/eng/about/who/nqpsd/qps-education/prospectus-of-education-and-learning-programmes.html

The QPS Ireland Network Map

To help visualise connections between people interested in quality, safety and improvement across Ireland: https://www.hse.ie/eng/about/who/nqpsd/qps-connect/network-map/

- How to join the map?
  - Visit the HSE website (see link in the chat)
  - Get sent your unique link to the map
  - Enter information about you, your professional characteristics and your interests
  - Log your connections

- How to use the map?
  - Filter the map by role, organisation, interests
  - View individual profiles
  - Connect and collaborate with others



Apply to become a member of

Q-Membership is not needed to join the Patient Safety Community, but we encourage anyone with an interest in quality and patient safety to explore all the supports freely available on the Q Community Website: https://q.health.org.uk/join-q/

For information on how to apply contact:
Mary.lawless@hse.ie / Roisin.Egenton@hse.ie

Website launched on 17th January

What is it?

- A new freely available online resource that shares patient safety learning & supports the HSE Patient Safety Strategy (2019- 2024)
- Enables users to access & download new and up-to-date QPS information.

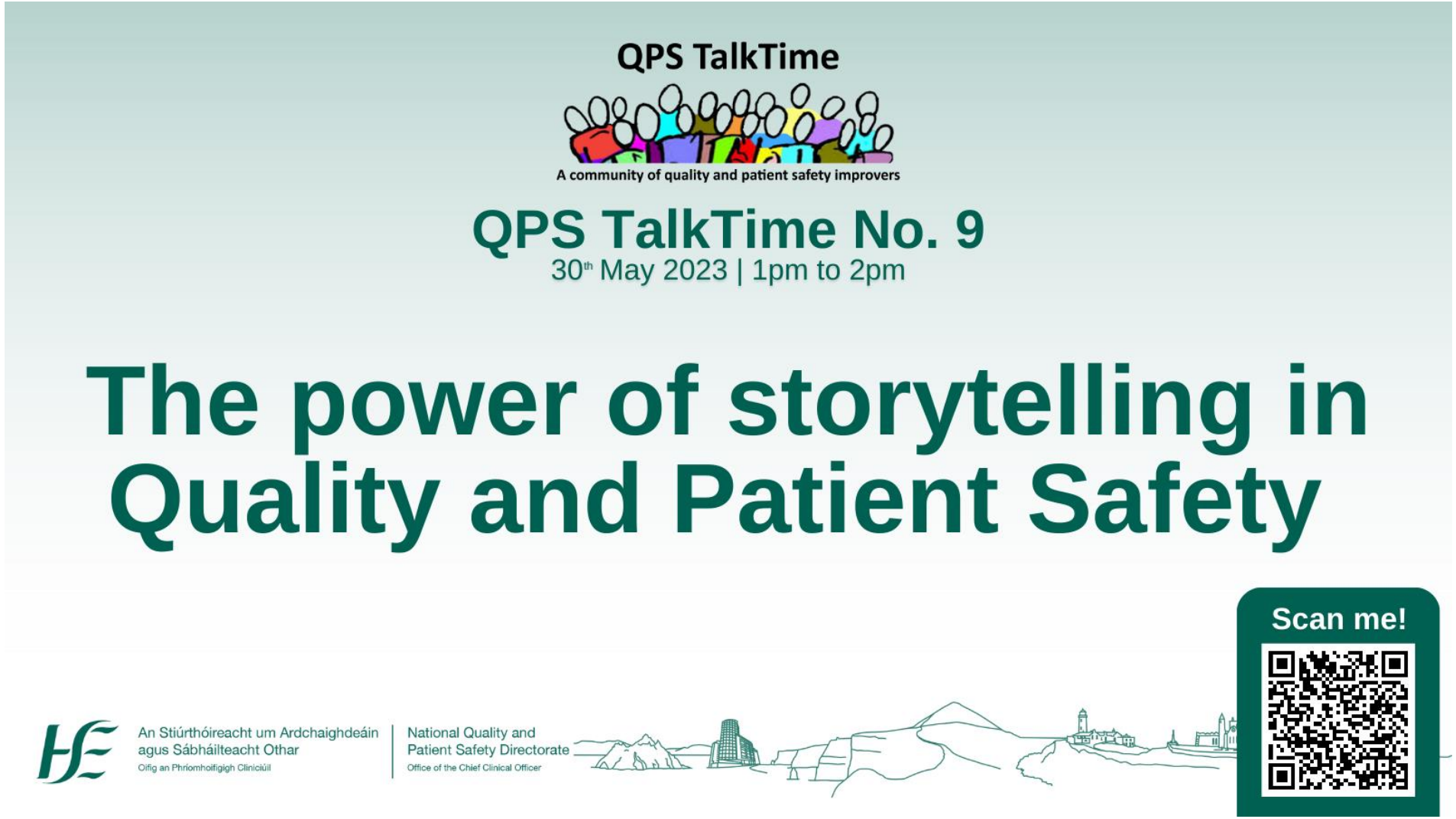
Resources will include:

- HSE National Patient Safety Alerts
- Patient Safety Supplements
- Patient Safety Stories
- Resources for further learning including Patient Safety Digest and QPS Community

Patient Safety Together | patientsafetytogether@hse.ie | www.hse.ie/pst/

Quality and Patient Safety Matters #AllThingsQuality

Upcoming Webinars, dates for your diary…



Connect with us

YouTube

HSE National QPS

@NationalQPS

Let us know how we did today ….

Reminder:
Short questions (pop up) as you sign off, please help us to improve our QPS Talktime Webinars by sharing your feedback

We really appreciate your time, thank you.

Contact:
Kris.Kavanagh@hse.ie to be included on our mailing list to receive QPS TalkTime invitations